

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**=62-041756**

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. **042** Primary Registration District No. **1000** Registrar's No. **1268**

STATE FILE NUMBER

**FILED NOV 19 1962**

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR <b>St. Joseph</b>		c. CITY OR TOWN <b>St. Joseph</b>	
Length of stay in 1b <b>30 Years</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>316 Edmond St.</b>		d. STREET ADDRESS (If outside, give location) <b>316 Edmond St.</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <b>MIKE</b>			First Middle Last <b>ZWONKA</b>			4. DATE OF DEATH <b>November 3, 1962</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>4-28-1890</b>	9. AGE (last birthday) <b>72</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Gun Shop Owner</b>	11. BIRTHPLACE (City and state or country) <b>Austria</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Not Known</b>			13b. MOTHER'S MAIDEN NAME <b>Not Known</b>			14. NAME OF HUSBAND OR WIFE <b>Victoria</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			17. INFORMANT <b>Henry Bell</b>			Address <b>San Pedro, Calif.</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>Atherosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in PART II of item 18.) <b>Pain in left arm and indigestion 3 weeks. Found dead in bed.</b>	
20c. TIME OF INJURY Hour <b>12:30 a.m.</b> Month <b>Nov</b> Day <b>3</b> Year <b>62</b>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. CITY, TOWN, OR LOCATION <b>St Joseph</b>	
COUNTY <b>Buchanan</b>		STATE <b>Mo.</b>	

21. I attended the deceased from **Viewed body**, to **1230 Am** on the date stated above, and to the best of my knowledge, from the causes stated.  
Death occurred at **1230 Am** on **Nov 3 62**

22a. SIGNATURE (Degree or title) <b>SF Melaney M.D. CORONOR</b>		22b. ADDRESS <b>214 Kirkpatrick Bldg. Saint Joseph 8, Mo.</b>		22c. DATE SIGNED <b>11/7/62</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Nov. 8, 1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Joseph, Mo.</b>
24. FUNERAL DIRECTOR <b>H. O. Sidenfaden &amp; Son</b>		25. DATE RECD. BY LOCAL REG. <b>Nov. 13. 1962</b>		26. REGISTRAR'S SIGNATURE <b>Mrs. Clark Hardell</b>

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK

OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

INSTEAD OF

DATE AMENDED

DOCUMENT

BY AFFIDAVIT OF

Medical Certification

SF Melaney M.D.

VS 300  
Rev. 4/59  
1 5117  
2 5117  
3  
4 0  
5 2  
6  
7 2  
8 2  
9 4201  
10  
11  
12 90-3  
13 1-0

Permit issued 11/8/62

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. 3308

P. O. Address St. Joseph, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.